U.S. Department of Defense
Uniform Formulary Beneficiary Advisory Panel

Meeting Summary
March 23, 2005
Washington, D.C.

Panel Members Present:

- Colonel James Young, USAF, TRICARE Management Activity, DFO
- Deborah Fryar, Military Coalition
- Jan Prasad, TriWest
- Susan Schwartz, Military Coalition
- Martha Miller, Health Net Federal Services
- Robert Washington, Military Coalition
- Lisa LeGette, TRICARE Retail and Mail Order Pharmacy
- Sydney Hickey, Military Coalition
- Charles Partridge, National Military and Veterans Alliance
- Rance Hutchings, Uniformed Services Family Health Plan
- Jeffrey Lenow, Medical Professional

The meeting was held at the Naval Heritage Center Theater, 701 Pennsylvania Ave., N.W., Washington, D.C. Col Young, the Designated Federal Officer (DFO), called the proceedings to order at 8:00 A.M. He welcomed everyone present to the first meeting of the Panel and expressed appreciation for their interest and participation. He said the Panel will be engaging in a process that is different from any other used by DoD. The Panel members, who have been designated as "Special Government Employees," are also special people – dedicated, experienced and committed to their role of representing all DoD health care beneficiaries. This Panel is a key point in developing the DoD Uniform Formulary, is key to the ongoing development of the DoD TRICARE pharmacy program and will impact the budget.

The meeting agenda includes a time for comment from private citizens. No private citizens have signed up in advance, but the opportunity will be held open for a few more minutes. Col Young noted that the meeting is open to the public and that members of the press may be present.

Col Young commented that the process of forming the panel has been difficult and time consuming, taking more than a year. Additional nominations are still pending. He thanked the Panel for their patience with the process, noted that members represent the interests of more than nine million beneficiaries and serve without compensation. He assured the Panel that its comments would impact the development of the DoD Uniform Formulary.

Col Young introduced several members of the TRICARE Management Activity (TMA) staff, including Col (Ret) Pat Hobbs, LtCol Michele Williams, MAJ Travis Watson, Vendella Jordan, Lynn Burleson (Office of General Counsel), CDR Mark Richerson (Director of the Pharmacoeconomic Center), CDR Denise Graham (Pharmacoeconomic Center) and LtCol David Bennett (Pharmacoeconomic Center). The latter two individuals will brief the Panel later today.

Col Young announced his intention to stick to the pre-announced schedule as much as possible. Because the schedule was announced on the website in advance, some people may be planning to attend a particular session at a given time. Col Young then reviewed logistical considerations related to the meeting facility.

Panel Meeting Rules

Col Young next reviewed the rules under which the Panel meeting will be conducted.

- Only the Panel will actively participate in the meeting.
- Only the Panel will address questions to the briefers.
- Audience comments are limited to the allotted time period (8:30-9:30) and to only those individuals who signed up in advance and have been designated and approved to address the Panel.
- All comments made today will be public. The Panel has received one comment from a private citizen that was submitted electronically. It will be read into the record during the designated time period.
- Public speakers are limited to a strictly-enforced five minutes.

Today's Meeting Objectives

Col Young briefly introduced the Panel members attending today's meeting (see list on page 1). He said individuals who are now Panel members received ethics briefings and introductory instructions about the processes used by the DoD Pharmacy and Therapeutics (P&T) Committee in August, 2004, but stressed that the group's first meeting is being held today.

Today's meeting will deal with recommendations made by the P&T Committee at its meeting in San Antonio, Texas, on February 15 and 16, 2005. Col Young noted that in the past the P&T Committee had been a decision-making body, but it now makes recommendations instead. Today the Panel will review recommendations regarding drugs in the Angiotensin Receptor Blocker (ARB) class, the Proton Pump Inhibitor (PPI) class, and Prior Authorizations. The P&T Committee has already made its recommendations regarding these drugs and the BAP is charged with reviewing those recommendations and making comments on them. The comments will be forwarded to the Director of the TRICARE Management Activity (TMA) who will make the final decision on whether to approve, disapprove or modify the recommendations.

The minutes of the meeting are being recorded and will be published. All comments made today are for the record.

As already noted, the time between 8:30 and 9:30 was reserved to hear comments from any private citizens who wish to address the Panel. The agenda allotted a maximum of 5 minutes each for up to 12 people to address the Panel with the time limit strictly enforced. The time is to be used only for public comments – not product endorsements, marketing strategy presentations or industry comments. Only private citizen comments will be allowed and only during the allotted time. Other comments or comments at other times will not be accepted. The audience members are considered observers, but Col Young said he and Mr. Martel would welcome their comments on the process.

Col Young then announced that no public members had appeared to address the panel, a situation which had been anticipated, and the time would be used for Panel members to say a few words about themselves and to provide additional information about the Pharmacoeconomics Center (PEC) – how it is organized and its role in the process of making recommendations. After that, Col Young will speak briefly about the origin of the Uniform Formulary and how it applies to the Panel.

Panel Introductions

Panel members introduced themselves to the audience, identified what group they are representing as a member of the Panel and summarized their background.

Four Panel members represent the military coalition: Deborah Fryar, an active duty family member, works with the National Military Family Association and has a background in nursing; Susan Schwartz, Deputy Director of Government Relations for the Military Officers Association, is also a Registered Nurse (RN) whose spouse in an active-duty Marine; Robert Washington is Director of the Legislative Program for the Enlisted Men's Association and a retired Marine; and Sydney Hickey is an RN who is a retired family member and a consultant to the Military Health Care Association.

Two Panel members represent TRICARE network providers: Jan Prasad, who has a private practice in Phoenix represents TriWest; and Martha Miller, is a Medical Director with Health Net Federal Services and a family practitioner who has had experience on the Pharmacy and Therapeutics Committee.

Lisa LeGette, is a Clinical Program Manager for Express Scripts, Inc. who works with the TRICARE Retail and TRICARE Mail Order Pharmacy Program and is a pharmacist.

Charles (Chuck) Partridge, is a retired Army artilleryman representing the National Military Veterans Alliance and a consultant with the National Association for Uniformed Services.

Rance Hutchings is a pharmacist representing the Uniformed Services Family Health Plan.

Jeffrey Lenow, is an Associate Professor of Medicine, Jefferson College in Philadelphia. Originally an obstetrician, Dr. Lenow attended law school and is also a family practitioner. His current focus is on medical education.

Uniform Formulary Overview Briefing

Introducing the background briefing, Col Young quoted from an article in *Time (Europe)* magazine about wounded American soldiers in an Army hospital in Germany and their experiences there. He stated that the article emphasizes that the Panel's purpose is to focus on the program's beneficiaries. He said there may be a tendency to think of beneficiaries as being those in the over-65 category, but the article clearly points out that is not the case; the beneficiaries are all ages. Some are children; some are soldiers coming back from a current war. He said the Beneficiary Advisory Panel process probably adds more oversight and credibility to the P&T process than DoD has ever had. It's an important check and balance so that the system doesn't get caught up in only one thing and continue to focus on the benefits that are earned by and owed to beneficiaries.

The Uniform Formulary vision is to provide a world-class pharmacy benefit at all three points of service: retail, mail order and Military Treatment Facility (MTF). The main consideration for this panel is what is important to the beneficiaries. The strategy for realizing the vision is to clearly define what the different roles are; provide oversight (of which the Panel is an example); improve management resources; and ensure uniform, consistent and equitable drug therapy to meet patients' drug needs in an effective, efficient and fiscally responsible manner.

Col Young quoted an author from 1895 to the effect that, "Man has an inner craving for medicine ... a thirst for drugs. The desire to take drugs distinguishes man from his fellow creatures. It is one of the most serious difficulties with which we have to contend ... The doctor's visit is not thought to be complete without the prescription." He said many patients still feel that way today, as evidenced by the ever-increasing budget. That's why the Panel is here today.

Not long ago, DoD pharmacies were Medical Treatment Facility-centered and conducted with limited DoD-level policy. The DoD role was examined as part of the BRAC and DoD base closures. The response has been considerable and includes expanded access, automation, robust marketing initiatives and standardization. Today, 6.4 million unique users take more than 100 million prescriptions a year (not all of the 9 million beneficiaries use prescriptions and some use other health insurance). DoD has 536 prescription dispensing units in 121 Military Treatment Facilities. DoD has over 54,500 retail pharmacists in its retail network and one of the Nation's largest mail order pharmacies. MTFs account for about 56 percent of the pharmacy workload but only about 36 percent of the drug costs. Retail is about 31 percent of the workload and 52 percent of drug costs. Mail order is about 13 percent of the workload and about 12 percent of drug costs. Approximately $5 billion is allotted for the pharmacy benefit. Automation initiatives coming on line will help improve the process. Col Young introduced the Contracting Officer's Representatives for the Retail Pharmacy and TRICARE Mail Order Pharmacy (TMOP) programs, noting that they manage 44 percent of the agency's workload and have a tremendous responsibility. He also introduced Army and Navy MTF pharmacy consultants present in the audience.

About 19 percent of beneficiaries in the system are retirees and family members who are 65 and older and 34 percent are retirees and family members who are under 65. About 26 percent are active duty family members and 20 percent (1.8 million) are active duty servicemembers. The overall numbers are increasing at a rate of about 250,000 a year. About 52 percent of MTF users are active duty (most are on the base). Users under 65 years old amount to about 51 percent, but only 19 percent of the over-65 beneficiaries use a Military Treatment Facility (33 percent use retail almost exclusively).

Overall usage has been quite stable for mail order and MTF programs, but usage is rising for the retail program. Figures published in a January 2004 Drug Trends Report by ESI stated that per member per year costs continue to rise, increasing by 14.5 percent in 2003 for non-specialty drugs and 38.7 percent for specialty drugs. Projections show costs increasing by 125 percent over the next five years without active management.

Col Young said the cost per beneficiary for the under-65 population was about $326. The cost per beneficiary for the over-65 population is about $1,309. For all ages the per beneficiary cost was $911.

Overall costs for the pharmacy program amounted to approximately $1.7 billion for MTFs, almost $2.5 billion for retail and about $.5 billion for mail order, for a total of just less than $5 billion.

The MTF portion, which is approximately 56 percent of the workload, has 536 dispensing pharmacies. This used to be the core of the pharmacy business and remains a very vital part of it. It is important for the Panel to think in terms of "What is the cost of prescriptions for our beneficiaries?" The answer is rather complex, but basically amounts to: the acquisition cost of the medicine plus any overhead less any co-pay contributed by the patients. Costs vary by facility and by venue. In the MTFs, for example, there is no co-pay to offset the cost. In the retail area, the acquisition cost is currently higher than the MTF and there is also a dispensing fee, but those costs are offset by a co-pay that is three times greater than that of the mail order program. In the mail order program, the acquisition costs are similar to those for the MTF, there is also a dispensing fee and there is a co-pay offset but it is less than for retail. These variables make it difficult to speak to what the "true cost" is.

Things are changing. In FY 2000 the National Defense Authorization Act established the DoD Pharmacy and Therapeutics Committee as well as the Uniform Formulary Beneficiary Advisory Panel. Following that, Uniform Formulary parameters – such as prior authorization and requiring the availability of non-formulary drugs at retail – were established. Why do we have the new co-pay? As noted, the costs vary by how the drugs are dispensed. One way to influence prescribing habits and patients' choice is to require that patients contribute to the cost. It is considered "best practice" to move market share in order to negotiate a best price for the beneficiaries overall and for the government. Co-pay is also used to preserve access – to avoid having to eliminate something. It also helps to maintain the comprehensive benefit that DoD now provides. Col Young noted that there are significant differences in the co-pay amounts between military and civilian health care programs. A commercial managed-care organization has a generic co-pay of almost $9, a formulary brand co-pay of almost $19 and a non-formulary co-pay of over $32. The Federal Employee Health Benefit Program (FEHBP) amounts for the same categories are $10, $25 and $40. Medicare HMO co-pays are about $8, $20 and $40. The DoD program is less than these. One of the things the panel will be talking about today is putting some of the drugs into categories that are different from what they are now.

One benefit of the Uniform Formulary is that it allows access to all medication, even if it is not part of the core formulary. Col Young said that over time the number of items in the basic core formulary (that which is in every MTF facility) will change. That provides a management tool. Beneficiaries have input to the UF process through this Panel.

The FY 2004 National Defense Authorization Act redefined membership for the P&T Committee and for the Uniform Formulary Beneficiary Advisory Panel. The reason had to do with the procurement sensitivity of certain items and with the proprietary information associated with the process (such as the cost of providing a drug). The determination was made that the functions associated with the procurement process had to be confined to the government. The difficulty stems from the fact that the Beneficiary Advisory Panel meetings are governed by the Federal Advisory Committee Act (FACA) and are open to the public.
Col Young said that the Uniform Formulary rule encourages a more cost-effective use of a point of service in terms of beneficiary and provider choice. The rule allows beneficiaries to obtain non-formulary drugs when clinically necessary at the formulary co-pay amount. It also permits

prior authorization, requires non-formulary drug availability and establishes the P&T Committee and this Panel.

Col Young said some people have thought that there would be a "book" resulting from the uniform formulary rulemaking process. He said there will be no "book." He suggested the Panel might be most interested in the "non-formulary" portion of the process. The rule requires that non-formulary drugs be available at retail and mail order at a $22 co-pay unless medical necessity has been established (when the co-pay will become $9). The rule established the P&T Committee as the mechanism to identify third tier (non-formulary) drugs and prior authorizations. The Beneficiary Panel's role is to comment on the P&T Committee's recommendations.

DoD received 3,311 comments on the Uniform Formulary rule during the required comment period (April-June, 2003) – about half paper comments and half e-mail. The comments were compiled and considered and the final rule was published on April 1, 2004. Col Young shared a few of the public comments received with the panel. He said that the $22 co-pay amount is based on common industry practice, as required by the law. Regarding a comment that the rule would create excess paperwork for doctors, Col Young said the intent of the rule is to expedite the process. Concern was expressed about how beneficiaries and providers would be informed of formulary decisions. He said TMA Communications and Customer Service are responsible for education, in conjunction with the contractor. Newsletters and websites will also be used to help get the information out. Regarding the impact of non-formulary decisions on patients already using the medication, Col Young said common practice is to provide a limited transition period of up to 6 months to allow patients time to consult with their physician and make a decision on conversion. A comment also asked how new FDA-approved drugs will be evaluated and will new drugs be included in the Uniform Formulary only if approved by FDA? Col Young said the answer to that question is "yes" – new FDA approved pharmaceutical agents should be included on the Uniform Formulary unless the P&T Committee determines that it does not have a significant clinical- or cost-effectiveness advantage.

The process is to identify drug classes for consideration. Two drug classes were identified for the last P&T Committee meeting. Others have been identified and are published on the website. The relative clinical and cost-effectiveness will be analyzed by the Pharmacoeconomic Center and data will be collected for presentation to the P&T. The Committee will meet quarterly to consider the evaluations, deliberate and prepare recommendations. The recommendations will be reviewed by the Beneficiary Advisory Panel prior to their submission to the Director of TMA. The notification process occurs after that process has been completed.

Briefing on the Pharmacoeconomic Center (PEC)

CDR Mark Richerson, Navy Pharmacist and Director of the PEC, briefed the Panel on the DoD Pharmacoeconomic Center, which is located in San Antonio, Texas. He briefly reviewed his qualifications (19 years experience and a master's degree in pharmaceutical management) and said they are typical of the staff at the Center. He said the PEC is charged with providing the P&T Committee with analytical support. It conducts clinical effectiveness analysis and cost-effectiveness analysis. The Center was established in 1993. The staff is a combination of military, civil service and contractor personnel.

The process involves the Center assigning subject matter experts to evaluate an assigned class of drugs. The experts may be physicians or clinical pharmacists. They work independently to gather comprehensive data about the class using the open literature as a primary source supplemented as necessary by conversations with industry colleagues, other subject matter experts and physicians who are using the drugs. The Center's clinical analyses are very comprehensive. Economic analysis is not started until the clinical analysis is well underway. That process uses models that are partially dependent on the clinical analysis. The process of developing final evaluations is an "all hands" group process in which all of the Center's staff participates. This ensures a thorough review of all considerations. The staff distills the key considerations, including multiple options, for P&T Committee deliberations.

PEC staff members will be briefing the Panel today. The goal is to help the Panel by providing information that will lead to well-informed comments and recommendations.

Public Comments Received in Writing

Col Young announced that the Panel had received a written statement from an interested individual dated March 9, 2005 and read the following communication into the record:

"I am submitting my statement as an interested party with a unique composite of perspectives on the issue of the Basic Core Formulary (BCF) determinations for the angiotensin receptor blocker (ARB) class. First, I am a DoD beneficiary enrolled in TRICARE Prime and receive the ARB, Cozaar (losartan potassium tablets) at my local Military Treatment Facility. Second, I am currently employed by Merck & Co., Inc., in its Federal Healthcare Affairs Department. Merck & Co., Inc. is maker of Cozaar (losartan potassium tablets). Finally, I served 26 years as a pharmacist in the Navy. During that period I held positions as Specialty Leader for Pharmacy to the Navy Surgeon General and later the DoD Pharmacy Program Director during the very period that the legislation that addressed the Uniform Formulary was passed by Congress.

Recognizing that the stated purpose of the Uniform Formulary (UF) was to create a "uniform, consistent and equitable pharmacy benefit" that will give adequate access to beneficiaries across the entire Military Health System, I am urging the Panel to ensure that the Basic Core Formulary (BCF) includes all ARBs that provide FDA-approved indications that are particularly relevant to the profiles commonly seen in Military Treatment Facilities. While all ARBs are indicated to treat hypertension, it should be noted that only COZAAR is indicated to reduce the risk of stroke in patients with hypertension and left ventricular hypertrophy, but there is evidence that this benefit does not apply to black patients. It is also important to consider that COZAAR is indicated to reduce the rate of progression of nephropathy as measured by the occurrence of doubling of serum creatinine or end stage renal disease in patients with type 2 diabetes, nephropathy and hypertension. Accordingly, I urge the Panel to recommend that the BCF for this class ensure an appropriate breadth of agents.

In an effort to provide balancing information, below you will find selective important information from the package insert for COZAAR. In addition, I have enclosed the complete prescribing information.

Thank-you for your consideration of these comments. Should you wish more

information on this issue, I will be happy to respond to your questions."

(The communication is available in full, including enclosures, on the Panel's website at http://tricare.osd.mil/pharmacy/bap)

No questions were raised relating to this communication.

Prior Authorizations Review

Col Young next introduced one of the day's main agenda items – prior authorizations review. He said the staff of the Pharmacoeconomic Center had been asked to brief the Panel and answer questions. They were charged with providing the Panel with as much information as they thought the Panel would need to know in the time available. Col Young informed the Panel that it is not appropriate for the staff to discuss specific pricing information in public.

CDR Denise Graham, Director of Clinical Operations at the PEC, conducted the briefing for the PEC. She also introduced LtCol Dave Bennett of her staff who is responsible for the cost analysis conducted by the Clinical Operations Staff.

By way of background, she said that the P&T Committee is responsible for the development and maintenance of the Uniform Formulary. Its primary mission and goal is to uniformly, consistently, and equitably provide appropriate drug therapy to meet the clinical needs of DoD beneficiaries in an effective, efficient, and fiscally responsible manner. The objective is to encourage safe and effective pharmaceutical agents that will produce the desired outcome of drug therapy at a reasonable cost to DoD.

Clinical and cost analyses are conducted of agents relative to other agents defined in the same class for consideration by the P&T Committee for the Uniform Formulary. The P&T Committee considers the clinical and economic outcomes.

CDR Graham said the goal is not to provide the Panel with the same in-depth clinical and cost effectiveness analysis that was presented to the P&T Committee. Instead, she and LtCol Bennett will: (1) Review the key factors of the analysis to give the Panel a better understanding of what the P&T Committee considered. She repeated that the staff is not allowed to discuss the actual cost figures used in the cost model. (2) Review the P&T Committee's recommendations based on the relative *clinical* effectiveness of the agents (applies to the angiotensin receptor blocker and proton pump inhibitor drug classes). (3) Review the P&T Committee's recommendations based on the relative *cost* effectiveness of the agents (also applies to the angiotensin receptor blocker and proton pump inhibitor drug classes). (4) Review the P&T Committee's recommendations as to the effective date of any changes, which must be no more than 180 days from the final decision date but may be less. (5) Consider the review of existing prior authorizations.

The prior authorizations process implements rule 4 concerning FDA-approved drugs for which prior authorizations already exist. The recommended rules would provide a consistent benefit and avoid circumstances under which prior authorizations exist for very similar medications but

cannot be applied to newly-approved medications of the same type until recommendations can be made by the P&T Committee and approved by the Director of TMA, which may take several months. The recommendations pertain to the following four classes of drugs:

(1) *PDE-5 inhibitors* for erectile dysfunction. The rule says that any PDE-5 inhibitor that may become available for erectile dysfunction will be subject to the same prior authorization as the existing agents (viagra, cialis and levitra).
(2) *Injectable gonadotropins for infertility treatment.* As above any injectable gonadotropin for infertility treatment that may become available will be subject to the same prior authorization as existing agents (follitropin alpha, follitropin beta, urofollitropin and menotropin).
(3) *Antifungals for onychomycosis* (fungal infection of the nail). Any oral or topical antifungal that may become available for the treatment of onychomycosis will be subject to the same prior authorization as existing agents (ciclopirox, terbinafine)
(4) Growth hormone agents. Any growth hormone agent that may become available will be subject to the same prior authorization as existing agents (somatropin and somatren).

The P&T Committee's recommendation is that any new drug in the above classifications that may become available for use in treatment will be subject to the same prior authorization as the existing agents.

Questions on Prior Authorizations

Col Young queried the Panel to determine if any member had questions for CDR Graham.

Dr. Lenow observed that the existence of authorizations for selected agents implies that DoD has a model that defines the cost effectiveness of the agent. He asked how DoD tracks that, how often it revises its thinking and if there is a point at which it decides whether to drop a particular agent. CDR Graham says the Center looks at four factors: (1) safety issues; (2) high anticipated cost; (3) high risk of inappropriate use; and (4) use of high cost agents when more cost-effective agents are available. The Clinical Operations staff reviews authorizations to determine whether or not they are beneficial and how much DoD is spending on them.

Dr. Lenow noted that he was asking from a practitioner's standpoint and because in his environment he rarely has to deal with it except for the Medicaid population, where HMOs are notorious for their tedious and onerous policies regarding pre-authorization. He asked whether the system is friendly to physicians on the military side and whether they can get a quick turnaround or have to jump through hoops to get an authorization. CDR Graham responded that if the MTFs wanted to use the prior authorizations, they could. Now the emphasis is shifting to retail. She said she is not sure how many MTFs use the prior authorization process, but there is also a non-formulary process that is available that provides for a quick turnaround so that it is not arduous for either the patient or the provider.

Ms. LeGette said the forms are available publicly and on the website. It's about like filling out a prescription. Typically the process only takes one or two days. The feedback she gets from physicians is that the paperwork required is nothing out of the ordinary.

Regarding antifungals, Ms. Schwartz asked if topical antifungals are included. CDR Graham answered that both topical and oral antifungals are included. She also said that verifying the

presence of a fungal infection is critical to the course of treatment. Topical antifungals require a long course of therapy (48 weeks) and can be ineffective. They don't want to treat somebody for that long if the problem is not an active fungal infection. Ms. Schwartz asked how a beneficiary is supposed to get something to treat the infection if they can't demonstrate the appropriate culture. She commented that she thought that oral was the preferred course of treatment and that topical was the fallback.

Ms. Schwartz also asked about prior authorizations for members with other health insurance. The Contracting Officer's Representative for the Retail Pharmacy, CDR Jill Pettit, addressed the question. She said that there was a problem when the program first started – beneficiaries were having claims filled under their primary health insurance, which may not have required authorizations for that particular drug. The process was changed so that it does not require prior authorization for claims filed under other health insurance.

Ms. Hickey asked whether the same statement also applies to mail order pharmacies. The answer given was that when a claim from another insurer is filed with TMOP it goes to the TRRx contractor, so the application is still in effect. The staff member answering the question, LTC Don DeGroff, said he believes that DoD is the only health care plan that has what is called portable prior authorization allowing movement from one point of service to another with an established prior authorization. Multiple authorizations are not required to change points of service.

Decision on Prior Authorizations

Col Young summarized the question before the Panel.

The P&T Committee recommended the following: Any new drug in the following classifications that may become available for use in treatment will be subject to the same prior authorization as the existing agents:

- *PDE-5 inhibitors* for erectile dysfunction
- *Injectable gonadotropins* for infertility treatment
- *Antifungals* for onychomycosis
- *Growth hormone agents*

Col Young opened the issue for additional questions.

Mr. Partridge asked whether all of the agents in these classes in the current formulary require prior authorization. Are there any that don't require it?

CDR Graham replied that all of the agents in these four classes require prior authorizations.

Col Young noted that he would only vote in the event of a tie. He then asked for a Panel vote to concur with the P&T Committee recommendation. By a unanimous vote of 10-0, the Panel voted to concur with the recommendation regarding prior authorizations.

Angiotensin Receptor Blocker (ARB) Drug Class Review

Col Young opened the discussion of the drug class angiotensin receptor blockers (ARBs) by outlining the process to be used. CDR Graham and LtCol Bennett will present the factual background and analysis that was used by the P&T Committee for its deliberations and making recommendations. The discussion will focus on:

- Relative clinical effectiveness
- Relative cost effectiveness
- The implementation plan

Col Young will then briefly summarize the recommendations and then ask the Panel for discussion and questions. After that, the Panel will vote and make additional comments.

Relative Clinical Effectiveness

CDR Graham presented the background information on ARBs relative to clinical effectiveness. She identified several key factors, including their relative safety, clinical effectiveness, and clinical outcome. Seven ARBs are currently marketed in the U.S.:

Generic Name	Brand Name
• losartan	• Cozaar
• irbesartan	• Avapro
• valsartan	• Diovan
• candesartan	• Atacand
• telmisartan	• Micardis
• eprosartan	• Teveten
• olmesartan	• Benicar

All are available in combination with the diuretic hydrochlorothiazide.

The use of ARBs in the military health system has been increasing over the past five years and the drug class is currently in the top ten in terms of use and cost. In FY 2004, $77 million was spent on the ARB class across all three points of service – retail, mail order and Military Treatment Facilities. The top three used in military hospitals are valsartan, losartan and irbesartan. All seven ARBs are approved for treating hypertension. In addition, some ARBs have additional indications such as type 2 diabetic nephropathy and chronic heart failure. The P&T Committee agreed that in the military health system, ARBs are not recommended as first-line agents for treating hypertension due to their higher cost and fewer trials supporting mortality reduction compared to diuretics or angiotensin converting enzyme (ACE) inhibitors. The ACE inhibitors and ARBs have similar safety concerns regarding hyperkalemia, elevations of serum creatinine, angioedema and pregnancy category labeling. The ARBs have an incidence of cough similar to placebo. An ARB is an appropriate agent for hypertension if a patient cannot tolerate an ACE inhibitor.

Based on a relative clinical effectiveness review, the P&T Committee concluded:

(1) All seven ARBs have similar relative clinical effectiveness for treating hypertension.
(2) Candesartan and valsartan have similar relative clinical effectiveness for treating chronic heart failure.
(3) Losartan and irbesartan have similar relative clinical effectiveness for treating type 2 diabetics with nephropathy.
(4) All seven ARBs have similar safety and tolerability profiles.
(5) Valsartan, candesartan, losartan and irbesartan have higher clinical utility (overall clinical usefulness) relative to the three ARBs that are indicated solely for treating hypertension (telmisartan, eprosartan, and olmesartan).

The P&T Committee came to these conclusions after reviewing the following key questions: (1) Are there any differences in the ARBs indicated for hypertension? (2) Are there any differences in the efficacy of the ARBs used for treating chronic heart failure? (3) Are there any differences in the efficacy of the ARBs used for treating patients with type 2 diabetes and diabetic nephropathy? (4) Are there differences in the safety and tolerability profiles of the ARBs? To answer these questions, the clinical analysis evaluated information from randomized clinical trials (DoD and other).

Efficacy for Hypertension

As a result, the P&T Committee concluded that all of the ARBs reduced hypertension to a similar extent. A meta-analysis consisting of 51 trials and over 12,000 patients involved 6 of the ARBs (olmesartan was not included because it was not yet FDA-approved). In the trials, ARBs lowered systolic blood pressure by 7.5-10 units and diastolic blood pressure by 4.5-6.5 units. Separate trials for olmesartan showed similar effects. The P&T Committee agreed that there is no evidence that any one ARB is more efficacious than the others for lowering blood pressure.

CDR Graham said that the analysis of the efficacy of ARBs for indications other than hypertension is complicated by the fact that there are no head-to-head trials between ARBs.

Efficacy for Chronic Heart Failure

The P&T Committee agreed that in evaluating ARBs for treatment of chronic heart failure, the evidence of a favorable effect on clinical outcomes (reduction of hospitalization or death) is the most important factor.

Two ARBs – valsartan and candesartan – show clinical effectiveness for treating heart failure. Large randomized clinical trials of these two ARBs showed a reduction in the risk of hospitalization due to heart failure. One trial (the Val-HeFT trial) resulted in FDA approving valsartan for use with heart patients who are intolerant of ACE inhibitors. A second trial (the CHARM trials) supports the use of candesartan. The P&T Committee agreed that there was no evidence that either valsartan or candesartan was preferable to the other for treating chronic heart failure. None of the other five ARBs have clinical trials showing a reduction in clinically relevant outcomes related to heart failure, leading the P&T Committee to agree that valsartan and candesartan are preferable to the other five ARBs for treatment of heart failure.

Efficacy for Type 2 Diabetic Nephropathy

The outcome of interest is a reduction in the development of end-stage kidney disease, the need for dialysis or kidney transplants. The P&T Committee agreed that other effects are not as important as these outcomes. FDA has approved two ARBs -- losartan and irbesartan – for treatment of type 2 diabetics who have an elevated serum creatinine and proteinuria. Both drugs were evaluated in RENAAL and IDNT trials. Based on these trials, the P&T Committee agreed that there was no evidence that either losartin or irbesartan were preferable relative to the other for the treatment of renal nephropathy in type 2 diabetics. Since none of the other ARBs have outcome studies showing a reduction in clinically relevant outcomes related to type 2 diabetic nephropathy, the P&T Committee agreed that losartan and irbesartan were preferable to the other five ARBs for the treatment of type 2 diabetic nephropathy.

Safety and Tolerability

The next question considered by the P&T Committee was whether there are differences in the safety and tolerability of the ARBs. The P&T Committee concluded that there is no evidence that any one ARB is preferable to the others with respect to safety and tolerability. In controlled trials, all ARBs have adverse events similar to placebo and all tend to be well tolerated. Adverse events have generally been mild and transient in nature. There is no evidence of a difference in adverse effects or adverse effects drop out rate among the drugs. All have been associated with such adverse effects as hyperkalemia, elevation of serum creatinine and angioedema – side effects that are also known to occur with ACE inhibitors. All ARBs should be used with caution in the first trimester of pregnancy; none are recommended for use in the second and third trimesters.

P&T Committee Action

CDR Graham reviewed the five conclusions reached by the P&T Committee regarding the clinical effectiveness of ARBs (see above). She indicated that the P&T Committee voted to accept the conclusion that valsartan, candesartan, losartan and irbesartan have increased clinical utility – due to their evidence for uses in addition to hypertension – relative to the three ARBs that are indicated solely for treating hypertension (telmisartan, olmesartan, and eprosartan). It also agreed there is no evidence that any one ARB is more efficacious than the others for lowering blood pressure.

Relative Cost Effectiveness

CDR Graham next presented the information on the relative cost effectiveness of ARBs that was considered by the P&T Committee. She said the P&T Committee evaluated the costs of the agents in relation to the safety, effectiveness and clinical outcomes of the other agents in the class. Information included, but was not limited to, information available in the Code of Federal Regulations. To determine the relative cost-effectiveness, two separate economic analyses were performed: a pharmacoeconomic analysis and a budget impact analysis (BIA). The clinical effectiveness conclusions stated above were incorporated into the models. Given the results of the clinical analysis, a series of cost minimization analyses were conducted. These revealed that:

- Candesartan was more cost-effective relative to valsartan for the treatment of heart failure.
- Irbesartan was more cost-effective relative to losartan for treating type 2 diabetic nephropathy;
- Irbesartan was more cost-effective relative to the other ARBs for the treatment of hypertension;
- Eprosartan was not cost-effective relative to the other hypertension ARBs.

Based on this analysis, the P&T Committee concluded that eprosartan was not cost-effective relative to the other ARBs for treating hypertension.

P&T Committee Action

Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations, the P&T Committee recommended that the status of eprosartan be changed from "formulary" to "non-formulary." The P&T Committee also recommended that the other six ARBs (candesartan, irbesartan, losartan, olmesartan, telmisartan, and valsartan) maintain their formulary status with the formulary cost share.

Implementation Plan

CDR Graham next presented the implementation plan associated with the above recommendations. She said that relatively few patients are receiving eprosartan (brand name Teveten) at any Military Health System pharmacy point of service – less than one percent of all patients receiving ARBs. Consequently, the P&T Committee proposed a 30-day transition period for implementation of a decision by the Director, TMA, to classify eprosartan as "non-formulary" on the Uniform Formulary.

Prior to the P&T Committee meeting, the government had solicited a request for blanket purchase agreement (BPA) price quotes from manufacturers. One manufacturer subsequently filed a protest concerning this class with the Government Accountability Office (GAO). Any decision by the Director, TMA, concerning this class, including an implementation plan, may proceed. However, no award of a BPA based on these quotes will occur until after the GAO has issued a ruling on the protest. The TMA and PEC web sites will notify all interested parties when GAO has ruled on the protest and will indicate what subsequent decisions have been made.

MTFs are not allowed to have non-formulary pharmaceutical agents on their local formularies. MTFs will be able to fill non-formulary requests for non-formulary agents only if both of the following conditions are met: (1) the prescription is written by a Military Treatment Facility provider, and (2) medical necessity is established for the agent. MTFs may (but are not required to) fill a non-formulary prescription written by a non-MTF provider to whom the patient was referred as long as medical necessity has been established.

P&T Committee Action

The P&T Committee voted to recommend an effective date of 30 days from the final decision date if the Director, TMA, approves the P&T Committee's recommendation.

Panel Questions and Comments

Col Young next solicited questions and comments from the Panel on all of the areas just addressed relative to ARBs.

Ms. Hickey asked how the plan proposes to notify beneficiaries. Col Young replied that the Agency understands this is a big issue and that it is still working on it. He said the Communications and Customer Service will be working with his unit on this matter. They already know they will be using web site notices along with a newsletter. As far as individual patients are concerned, the organization is looking at the cost of notification. Mass mailings run over 70 cents per letter. He is concerned that any implementation plan adopted has to be sustainable.

Ms. Hickey offered the view that under these circumstances, she finds a 30-day notification period ridiculous. She understands there are budgetary considerations, but she is uncomfortable agreeing to any kind of implementation plan until she knows how the beneficiaries will be notified.

Dr. Prasad noted that two of the seven were found to be both clinically- and cost-effective and asked why there are still six on the formulary list. CDR Graham replied that they wanted to be sure that they kept an agent for hypertension, an agent for heart failure and an agent for type 2 diabetic nephropathy. Five different scenarios were considered. The scenarios other than the one recommended would affect too many beneficiaries and the cost of moving all but two ARBs off the formulary list would be excessive compared to the benefits. The recommendation was made from a beneficiary viewpoint.

Dr. Lenow said his understanding is that removing the one agent from the formulary was not a huge volume issue and that the impact would not be that profound. He said his first reaction was that ARBs are for people who can't tolerate ACE inhibitors. The real impact would come if DoD tried to identify why so many people are on ARBs in the first place instead of on ACE inhibitors. He is skeptical about so many people being ACE-intolerant. His question is: how did so many people get on ARBs and where was the screening mechanism to discourage the use of ARBs? CDR Graham said she agreed with the question. The difficulty is that the authority they have only allows them to put out guidelines stating that ACE inhibitors are preferred. They don't have criteria that tell providers how to determine whether ARBs are truly indicated.

Dr. Lenow asked what percentage of beneficiaries is being seen by non-military clinical personnel who are making decisions. He understands that DoD doesn't have a closed system like the VA where it can tell providers what they can and can't use. His assumption is that there are a lot of providers prescribing ARBs for retirees just because they aren't thinking straight. Are there any data to indicate what percentage of providers people are using for military benefit are beyond the control of the system? CDR Graham said she didn't know the numbers off the top of her head, but PEC has them. There is no way to implement the kind of screening Dr. Lenow is talking about at their level, but it could be done by individual MTFs. LtCol Bennett said the fact that DoD has started filling more prescriptions in the retail network than in MTFs indicates that the number of non-military physicians prescribing for military beneficiaries is growing.

Dr. Lenow commented that the frustrating part of the situation is that ARBs are in DoD's "top ten" as far as cost is concerned when the same results could be obtained at a fraction of the cost.

Mr. Washington inquired about the reason for the blanket purchase agreement protest filed with GAO. A staff member, Lynn Burleson, replied that the protest was filed in Georgia by Merck. They are taking exception to the way DoD has solicited prices that would be used as one factor in determining the cost to the government. Merck didn't like the fact that DoD was including costs of the retail pharmacy network, didn't like the use of Federal unit pricing and wanted DoD to list the relative importance of various evaluation factors. The status is that the formal filing has been completed with GAO and the decision is due not later than May 16, 2005.

Dr. Prasad noted that ARBs are used in large volume and also that there are conditions in which they have to be used. He asked if there is any way of sending a letter to doctors pointing out the facts of ACE versus ARBs as they were presented to the Panel today. Col Young replied that there are lots of ways TMA could do that and there are instances where that has been done. He said TMA wants to continue to support patient options. What is of primary importance to this Panel is the formulary. He said it is still early in the Uniform Formulary process and TMA is learning fast that there are lots of ways they can influence behavior.

Ms. Fryar asked if there is a standard guideline in place regarding when changes such as this one will take effect. CDR Graham answered that it has to be less than 180 days.

Mr. Partridge said he agrees that 30 days is going to be too short a time period under almost any circumstances. He asked what the one percent figure amounts to in terms of the number of patients. CDR Graham answered that it amounts to 2,184 patients.

Ms. Schwartz asked how PEC reconciled the fact that there are different prices for the different points of service in conducting its cost-effectiveness analysis. CDR Graham answered that the models used by PEC take into account the different prices for the different points of service. Adjustments were made to equalize the costs before they were entered into the model. LtCol Bennett said the cost minimization analysis is quite simple and is based on the cost by product for each point of service and looks at the utilization for each product.

Ms. Schwartz said she also agrees that the 30-day transition period is not adequate.

Ms. Fryar asked if figures are available regarding how the one percent of patients (2,184) who would be affected by the formulary change would be distributed by point of service. The answer provided was that 1,644 are retail patients, 527 are mail order and 13 are MTF.

Ms. LeGette said she, too, doesn't see how the 30-day changeover can be achieved. Her experience suggests that at least 90 days is required to move from a second tier to a third tier program. She also asked whether the notification process would be part of the implementation plan. Col Young replied that that was not considered to be part of this Panel's charter.

Ms. Hickey commented that she is concerned that a situation might arise in which beneficiaries with the same status might be receiving different benefits – the cost of the benefit might differ based on whether or not the MTF has a robust enough network to see the patient and then have the prescription written by an in-house provider based on medical necessity. If this situation arises, the cost to the beneficiary with the medical necessity would be less than the cost to a

beneficiary who does not have access to a robust provider network. This situation would apply to active family members, not retirees. She would not want a situation in which the benefits would be different depending on where the beneficiary is located.

Dr. Miller asked how the process will work going forward. She said the analysis clearly shows two drugs that are most cost-effective and would cover all the indications, yet we are looking at six on the formulary. She asked whether it is likely there will be further restrictions in the future, say a year from now, based on these findings. CDR Graham replied that the P&T Committee has a lot of classes to go through. The organization wants to see how the process is going to work and how the recommendations get implemented for more of these classes before going back to a class and getting into higher impact recommendations. A staff member, Lynn Burleson, added that under the statute, agents are presumed to be in the formulary. Only if an agent does not have a significant, clinically meaningful therapeutic clinical advantage affecting safety, effectiveness or clinical outcomes over the other drugs may it be moved to non-formulary.

Mr. Partridge asked what it means to be removed from the formulary. Does that mean that the drug won't be available at all or that it will be available for $22? The answer given was that it will be available, but at a higher co-pay. To get the drug at the lower co-pay, the beneficiary will have to meet other criteria. The non-formulary drug will not be on the MTF formulary.

Mr. Hutchings also expressed concern about the 30-day time period. He suggested it might be useful to separate out new patients from those who are already on the drug. He believes that 30 days is a valid time for keeping new beneficiaries from going on a drug that will be going off formulary. He asked if there is a way to differentiate, grandfathering prior authorizations for 90 days. Col Young answered that the approach sounds reasonable and has been discussed.

Dr. Prasad asked whether the Panel is supposed to vote on the formulary status of the other 6 ARBs today. The answer given was that the options available to the Panel which will be reported to the Director of TMA are (1) concur with the recommendations; (2) not concur with the recommendations; and (3) provide additional comments.

Ms. Schwartz asked what is the best way for associations to communicate the recommendations and decisions to members in view of the protest. How long will the protest take? How will it affect the recommendations? One answer is that the drug recommended for non-formulary is not the subject of the protest, so there shouldn't be any impact there. If the protest is denied, there will be no impact on this process. If the protest is sustained, the government will have to go back and change the way it solicits the price quotes. It's possible, although not probable, that the resulting re-work of the analysis might change the evaluations. Col Young said again that when GAO makes its decision (by mid May), TMA will revisit the process and notify everybody.

Ms. Hickey asked for clarification on the concur/non-concur vote. She asked whether the Panel has to take the whole thing as a unit, including the implementation plan. Col Young replied that the votes will be separated. The first will be on the clinical- and cost-effectiveness recommendations, taken together. The second will be on the implementation plan.

Panel Summary and Vote on ARB Recommendations

(a) Clinical Effectiveness and Cost Effectiveness

Col Young summarized the P&T Committee conclusions detailed above regarding (1) relative clinical effectiveness, and (2) relative cost effectiveness. He repeated the P&T Committee's recommendation that eprosartan's status be changed from formulary to non-formulary, with candesartan, irbesartan, losartan, olmesartan, telmisartan and valsartan maintaining formulary status, with the formulary cost share, under the Uniform Formulary.

The Panel approved the recommendation by a vote of eight for and two against.

Dr. Prasad commented that six ARBs remain in formulary status. Four of these have outcome-based trials. He would prefer to wait on the other two, until they have outcome-based trials.

(b) Implementation Plan

Col Young next called for the Panel vote on the P&T Committee's implementation plan recommendation. The P&T Committee recommended an effective implementation date of 30 days from the final decision date if the Director, TMA, approves the P&T Committee's recommendation.

The Panel vote was as follows: one member concurred and nine members did not concur.

Additional comments offered were:

- The Panel needs to know the notification process to be used to communicate the decision to beneficiaries before approving the implementation plan.
- The proposed MTF non-formulary/formulary rule should be reviewed in regard to making a non-formulary agent available to address the issue of possibly having two people in the same status with different benefits.
- The proposed 30-day period is unacceptable for beneficiaries already receiving medication but should be sufficient for new patients who are not already receiving the medication.
- The implementation period should start with the legal limit of 180 days and work backward from there. Beneficiaries using the retail program will be the hardest to notify. Those using mail order and MTF can be notified relatively easily.
- The differences in co-pay between the formulary ($9) and the non-formulary ($22) can be magnified for beneficiaries by up to three times ($66 instead of $27) for those whose prescriptions are filled on a 90-day basis, which is a common practice of retail pharmacies.

Proton Pump Inhibitor (PPI) Drug Class Review

Col Young introduced the discussion on the Proton Pump Inhibitor drug class. He indicated the format would be the same as that used for the ARBs: relative clinical effectiveness, relative cost

effectiveness and Uniform Formulary implementation plan. After a briefing by PEC staff, there will be an opportunity for the Panel to ask questions. The Panel will then vote and have the chance to offer formal comments.

Relative Clinical Effectiveness

LtCol Dave Bennett, PEC, presented the briefing on the relative clinical effectiveness of proton pump inhibitors. He began by emphasizing the Code of Federal Regulations establishes relative clinical effectiveness and cost effectiveness as the basis for including pharmaceutical agents in the Uniform Formulary. Appropriate cost-effective modeling can only be conducted after determining the relative clinical effectiveness. Therefore the PEC methodology for class analysis always begins with a clinical review, followed by the cost analysis. The clinical review of PPIs took into consideration the relative safety (the likelihood to do no harm) and efficacy (the likelihood the agents will work).

Five PPIs are marketed in the United States:

Generic Name	Brand Name
• omeprazole	• Prilosec, Zegerid & generics
• lansoprazole	• Prevacid
• rabeprazole	• Aciphex
• pantoprazole	• Protonix
• esomeprazole	• Nexium

PPIs are indicated for the treatment of Gastro Esophageal Reflux Disease (GERD) and Peptic Ulcer Disease (PUD) and also for hypertrophic conditions. None of the PPIs has received FDA approval for all combinations of indications. However, a determination has been made that all agents are sufficiently similar that they may be used interchangeably for all indications.

Some of the PPIs are indicated for treatment of the pediatric population. Rabeprazole is approved for children over the age of two and omeprazole is approved for treatment of children between the ages of two and sixteen. Less than one percent of the PPI users in the Department of Defense population are under the age of 18.

In FY 2004, PPIs were the second highest drug class in terms of expenditures for the military healthcare system with $391 million spent across all three points of service:

- $91 million in MTFs (1.4 million prescriptions);
- $53 million in mail order (325,000 prescriptions);
- $247 million in retail (1.6 million prescriptions).

Utilization varies according to point of service. In the MTFs, rabeprazole and lansoprazole are the most utilized PPIs. In mail order, omeprazole is the most utilized, although this point of service has the most parity among PPIs of all the points of service. In the retail network, esomeprazole is the most widely used PPI.

The P&T Committee was primarily interested in the answers to two questions:

- Are the available PPIs sufficiently similar in efficacy, safety, tolerability and other factors to be considered clinically interchangeable?
- Is it clinically acceptable to move one or more PPIs to "non-formulary" status under the Uniform Formulary?

Efficacy

LtCol Bennett noted the random data sources included in the evaluation of PPIs, including randomized clinical trials identified through an online search, the VA pharmacy benefit and clinical review and the Oregon Health Services Commission PPI review. Manufacturers were invited to provide information and the FDA web site was monitored. LtCol Bennett also summarized the generally accepted therapeutic equivalents of the different PPIs: esomeprazole 20 mg, lansoprazole 30 mg, omeprazole 20 mg, pantoprazole 40 mg and rapebrazole 20 mg were found to be the therapeutic equivalents of each other. For the treatment of GERD, results were examined in 16 randomized controlled head-to-head trials. These trials were included in a meta analysis by the Oregon Health Resources Commission. Five studies compared lansoprazole with omeprazole; two studies compared rabeprazole with omeprazole; two studies compared pantoprazole with omeprazole; two compared esomeprazole with omeprazole; two studies compared esomeprazole with lansoprazole; one study compared omeprazole, lansoprazole and pantoprazole; and one study compared lansoprazole and pantoprazole. The results of this analysis showed that in four to eight weeks all PPIs are effective. A more recent study showed that esomeprazole has a small but statistically significant advantage over omeprazole. The P&T Committee did not consider this difference to be clinically significant. The P&T Committee came to the conclusion that there was insufficient evidence to think that any one PPI was more efficacious than another in treating for GERD. Similarly, the P&T Committee came to the conclusion that there was insufficient evidence to think that one PPI was more efficacious than another in treating duodenal ulcers.

Safety and Tolerability

Regarding safety and tolerability, PPIs are only contraindicated when patients have a known sensitivity to a particular agent. None of the PPIs is recommended for patients with chronic renal insufficiency. Omeprazole is a pregnancy category C agent; the others are pregnancy category B. PPIs are not recommended for use by expectant mothers. There is no clinically significant difference between PPIs in terms of their profile. In terms of adverse effects, the frequency of adverse effects associated with PPIs is similar to that of placebos (less than five percent overall). The most common adverse effects are headache, diarrhea, abdominal pain and nausea. The P&T Committee's conclusion was that there was no evidence to suggest that one PPI was preferable to another with respect to safety and tolerability.

P&T Committee Conclusion

The P&T Committee's overall conclusion from the clinical review was that all five PPIs demonstrate similar relative clinical effectiveness for treating GERD and peptic ulcers and all five have similar safety and tolerability profiles.

Panel Questions

Ms. Schwartz noted that the information indicates that the drug omeprazole has a generic. She asked if there is a price difference. LtCol Bennett answered that there is. Ms. Schwartz asked how that price difference was taken into account in the analysis. LtCol Bennett said the generic pricing for omeprazole was used in the clinical review. Ms. Schwartz asked whether a patient could get Prilosec or whether they have to get the generic. LtCol Bennet said they have to get the generic. CDR Graham added that TMA is still early in the process and is having to work out how to handle it where lots of generics are involved.

Relative Cost Effectiveness

LtCol Bennett next briefed the Panel on the relative cost effectiveness analysis for PPIs. In considering the relative cost effectiveness of pharmaceutical agents in this class, the P&T Committee evaluated the costs of the agents in relation to the safety, effectiveness and clinical outcomes of the other agents in the class. Information considered by the P&T Committee included but was not limited to the sources listed in the Code of Federal Regulations. Two analyses were used to determine the relative cost-effectiveness of agents in this class: a pharmacoeconomic analysis using cost-minimization techniques and a budget impact analysis. Cost minimization was chosen for the pharmacoeconomic analysis because the clinical analysis determined the outcomes of interest (effectiveness, safety and tolerability) to be similar among all PPIs.

The results of the cost minimization analysis showed omeprazole (the generic) to be the most cost-effective PPI across all points of service (retail, mail order and MTF). This was followed by rabeprazole, lanoprazole and pantoprazole. It was determined that esomeprazole was not cost-effective relative to the other PPIs.

The results of the cost minimization analysis were then incorporated into a budget impact analysis, which accounts for other factors and costs associated with a potential decision regarding formulary status of PPIs within the Uniform Formulary. These factors included market share migration, cost reduction associated with non-formulary cost shares, medical necessity processing fees, and switch costs. The results of the budget impact analysis further confirmed the results of the cost minimization analysis. Esomeprazole was found not to be cost effective relative to the other PPIs.

P&T Committee Conclusion

The P&T Committee concluded that esomeprazole was not cost effective relative to the other PPIs. Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the PPIs and other relevant factors, the P&T Committee recommended that esomeprazole's status be changed from "formulary" to "non formulary."

P&T Committee Action

The P&T Committee voted to recommend "non-formulary" status for esomeprazole, with rabeprazole, lansoprazole and pantoprazole maintaining formulary status at the formulary cost share and omeprazole maintaining formulary status at the generic cost share.

Panel Questions

Ms. Hickey asked whether "switch costs" include the cost of switching either to the MTF or to a contractor with additional visits. The answer given was that "switch costs" pertain to the cost to the military health system. They include the difference to the system resulting from the different co-pay costs associated with moving from one tier to another. It also includes the costs of additional physician visits.

Dr. Prasad asked which of the "middle three" drugs -- rabeprazole, lansoprazole and pantoprazole – was most cost-effective. The answer given was that the agents broke into three main groups. Esomeprazole was clearly the least cost-effective. Lansoprazole and pantoprazole grouped together. Rabeprazole was very close in cost-effectiveness to omeprazole. Omeprazole would be the next most cost-effective agent.

Mr. Partridge asked what would be the practical effect on other drugs available at the MTF formulary of implementing the P&T Committee's recommendation. The answer was that all of the drugs except esomeprazole would remain available at the Uniform Formulary at the standard co-pay. They would be available for the MTFs on their formulary. Individual MTFs have some latitude as to how many of these they actually put on their formulary but the P&T Committee would not require any action.

Ms. Hickey observed that does not assume they would not be part of the basic core formulary that must be carried. LtCol Bennett said that is correct. CDR Graham added that the P&T Committee's recommendations would be part of the decision-making process described earlier about what would be included in the basic core formulary.

Mr. Partridge asked whether a decision has been made as to which of these will be included in the basic core formulary. The answer provided was that the core formulary decision is a separate process. What the Panel has in front of it is just a recommendation.

Dr. Prasad said that the comment he made earlier about ARBs would also apply to this class. There are three drugs that are about the same. He understands that there may be differences for the patient. He still thinks it doesn't make sense to have three very similar PPIs with formulary status. The response was that the number of users who would be affected was taken into consideration. The current proposal would affect 15 percent of all DoD patients taking PPIs (about 138,000 patients, of which 117,620 are in the retail network; 6,691 in MTFs and 13,528 in mail order). Overall, about one million DoD patients are taking PPIs. Some of the other proposals would affect up to 50 percent of these beneficiaries. The number of patients affected was a major consideration.

Mr. Partridge asked how many and which of the four are recommended to be on the core formulary. CDR Graham replied that she can't speak to that matter until the recommendation is finalized and the decision is made. Mr. Burleson added that the General Counsel has determined that decisions on the basic core formulary are an inherently governmental function and therefore are not subject to the BAP process.

Implementation Plan

Because a substantial number of patients are currently receiving esomeprazole from one of the three MHS pharmacy points of service (138, 739, or 13.4 percent of all patients receiving PPIs), the P&T Committee proposed a 90-day transition period for implementation of the decision to change esomeprazole to a non-formulary drug on the Uniform Formulary. Patients wishing to fill prescriptions for esomeprazole at retail pharmacies or the TMOP would then have to pay the non-formulary cost share unless medical necessity for esomeprazole is established.

Prior to the implementation of the Uniform Formulary, the former P&T Committee had made a decision that prescriptions for esomeprazole could not be filled through the mail order venue (TMOP) unless medical necessity was validated. If the Director, TMA, concurs in the P&T Committee's current recommendation, prescriptions for esomeprazole may be filled through the TMOP, but will require payment of the non-formulary cost share of $22. Beneficiaries who already have a medical necessity validation on file at the TMOP are required to re-establish medical necessity for esomeprazole under the medical necessity criteria approved by the Director, TMA, in order to receive esomeprazole at the formulary cost share.

MTFs will not be allowed to have esomeprazole on their local formularies. MTFs will be able to fill non-formulary requests for esomeprazole only if both of the following conditions are met: (1) the prescription must be written by a MTF provider, and (2) medical necessity must be established for esomeprazole. MTFs may (but are not required to) fill an esomeprazole prescription written by a non-MTF provider to whom the patient was referred by the MTF as long as medical necessity has been established.

P&T Committee Recommendation

The P&T Committee voted to recommend an effective date of 90 days from the final decision date – the date that P&T Committee minutes are signed by the Director, TMA, approving the Committee's recommendations.

Panel Questions

Mr. Washington said he finds the statement confusing that MTFs are not allowed to carry the drug but yet you can fill a non-formulary request at the MTF. Are they allowed to carry it or are they not allowed to carry it? The answer given was that the decision is at the discretion of the local leadership of the MTFs. They don't necessarily have to fill the prescription. Col Young added that the drug cannot be on the formulary. Therefore if you walk in off the street with a prescription, the response should be that the drug is not on the formulary. However, if a medical necessity is established, the prescription can be filled for the patient. The process must be repeated for each new prescription.

Ms. Hickey said she assumes that the current medical necessity criteria will change such that if a patient already has a medical necessity established for the TMOP he or she will have to get a new one. The response was that the assumption is correct. Part of the implementation process for this class of drugs will be to develop a standard medical necessity formula for use across all points of service.

Ms. Hickey asked whether the standard medical necessity criteria would apply to all drugs or just this class. The answer was "just this class." Ms. Hickey said she understands that the Panel is not being asked to comment on medical necessity. But it is difficult to make decisions without knowing what the medical necessity criterion is. CDR Graham read a list of the criteria established in the Uniform Formulary final rule.

Ms. Schwartz observed that a lot of people have gotten a medical necessity determination. The 90-day transition period will affect a sizeable number of the 13 percent of patients who will have to re-do their medical necessity determinations. The 90 days may not be adequate. She said she is really uncomfortable with the 90-day period in the implementation plan.

Ms. Hickey said she agrees. She thinks the plan should provide the whole six months allowed by the law for implementation until we know what the notification process will be.

Mr. Partridge said he agrees with that, also.

Ms. Hickey said her previous comment about identical beneficiaries having to pay different amounts for their drugs would also apply to this class.

Dr. Miller said it's been established that all these drugs have the same healing effect. One is clearly the drug of choice. It is recommended that others be kept off the formulary. We could be looking at real cost savings to the government if we had just two instead of the four.

Mr. Hutchings said he believes the real cost issue stems from over utilization of PPIs. PPIs should only be used for four weeks, but many people on PPIs stay on them.

Panel Summary and Vote on PPI Recommendations

(a) Clinical Effectiveness and Cost Effectiveness

Col Young summarized the P&T Committee's conclusions (detailed above) with regard to the relative clinical effectiveness and relative cost effectiveness of the five PPI agents in this drug class. He stated that the recommendation is to change the status of esomeprazole from "formulary" to "non-formulary;" maintain rabeprazole, lansoprazole, and pantoprazole in "formulary" status with the formulary cost share; and maintain omeprazole in formulary status with a generic cost share.

The Panel vote was as follows: seven members concurred with the recommendation; two members did not concur with the recommendation. One panel member abstained.

Panel Comments

Dr. Prasad reiterated his earlier comment that it doesn't seem sensible to have so many different PPIs with similar effectiveness in formulary status.

Mr. Partridge said he understands that different people react to different drugs in different ways. Although they may have the same clinical effectiveness, one may work for some people and not for others. From a beneficiary viewpoint he would like to see as much choice as possible, recognizing that cost has to be a consideration.

Dr. Prasad said it is up to the provider to send a letter when a drug is not helping. If the provider documents the situation, the drug will be available.

Mr. Partridge said he would also like his question about which of the drugs will be recommended to be on the basic core formulary to be included, if that is appropriate.

(b) Implementation Plan

Col Young stated the P&T Committee's recommendation for an effective date of 90 days from the TMA Director's final decision date.

The Panel vote was as follows: three members concurred, six members did not concur and one member abstained.

Panel Comments

Ms. Hickey reiterated that it is difficult to comment or make decisions on the implementation plan before knowing how beneficiaries will be notified.

Ms. Hickey also asked that her comment about the potential difference in cost for identical benefits be included in the Panel's report.

Ms. Schwartz asked that a comment be included about 90 days being too short a period of time, especially for those beneficiaries who will have to re-establish medical necessity for TMOP services.

Mr. Hutchings pointed out that 90 days would be sufficient if the medications were used as intended – for only a four week period. He also would like to see a differentiated implementation period for those who are already on the medication and those who have never been on it before.

Procedural Comments

Having completed the main portion of the meeting, Col Young next offered the Panel a chance to ask any additional questions, offer observations on what went right and what went wrong, what changes should be made and what could have been done better. He also said he would ask the audience for feedback after the Panel is finished.

Ms. Fryar said it would be better to get the read-ahead information at least two weeks before the meeting. She would also like the advance information to be more inclusive – what methods were used, what demographics pertain to the recommendation, for example.

Ms. Hickey complimented the process and agreed with the need to have materials earlier. She also said the organization should let the Panel know when it is going to publicize things before the meeting that the Panel has been told not to release.

Mr. Hutchings said it would be helpful if the Panel could plan to have shorter meetings since it got so far ahead of schedule today.

Dr. Lenow observed that this is an open meeting and presents a great opportunity to bring some students in from the medical colleges to let them watch. There is enough room.

Mr. Partridge said the venue was great. Also, as a lay person he appreciates having the pharmacists and physicians on the Panel. And nurses.

Mr. Washington complimented the process and said it was a good experience for him.

Mr. Hutchings said he would like to have a better idea about what the P&T Committee's thought processes were regarding transition times. CDR Graham acknowledged that the P&T Committee was going through the process for the first time, too, and based most of its recommendations on the number of patients that would be affected. She said it will be very beneficial for them to get the Panel's views and recommendations.

An audience member suggested that presenters do more to define acronyms and bring the presentation down a notch by using more common sense terms we can all understand. He also said he doesn't understand why the basic core formulary process can't be discussed – it's part of the Uniform Formulary. He thinks the questions raised about which drugs would be in the core formulary were valid and that the Panel should have the right to know. Mr. Burleson from the General Counsel's Office agreed to check on the matter further.

Another audience member observed that the use of visuals is important and suggested that greater use be made of them for presenting data and briefing information.

Ms. Schwartz said she hopes the appointment process for panel members can be sped up. She said she was appointed to the Panel five years ago. The process should be expedited for the remaining individuals.

She also agreed that it is important and valuable to have the different perspectives that the individual Panel members bring to the table.

An audience member said that part of the problem with public comments was timing. Materials weren't released early enough for the public to react to them in the prescribed time frame. It is difficult for interested private citizens to comment without having a better sense of what the findings and recommendations are. Col Young acknowledged the problem and said he will attempt to get it out as early as possible in the future.

Col Young closed the meeting by thanking the Panel as well as the staff members who worked to put the meeting together. He indicated that the discussion might have strayed somewhat from the Panel's charter today; there is a balance to how far the Panel should and should not go and he knows that. He announced that the next meeting of the Panel will be on June 27 in the same location – the Naval Heritage Center at 701 Pennsylvania Ave., NW, Washington, D.C. Col Young adjourned the meeting at 2:30 P.M.

Brief Listing of Acronyms Used in This Summary

Abbreviated terms are spelled out in full in this summary; when they are first used, the acronym is listed in parentheses immediately following the term. All of the terms used as acronyms are listed below for easy reference. The term "Panel" in this summary refers to the "DoD Uniform Formulary Beneficiary Advisory Panel," the group whose meeting is the subject of this report.

- ACE – angiotensin converting enzyme inhibitors (class of drugs).
- ARB – Angiotensin Receptor Blocker (a drug class)
- BAP – DoD Uniform Formulary Beneficiary Advisory Panel (the "Panel" referred to above)
- BIA – Budget Impact Analysis
- BPA – Blanket Purchase Agreement
- BRAC – Base Reduction and Closure Program
- CFR – Code of Federal Regulations
- DFO – Designated Federal Officer
- DoD – U.S. Department of Defense
- ESI – Express Scripts, Inc.
- FACA – Federal Advisory Committee Act
- FDA – U.S. Food and Drug Administration
- FEHBP – Federal Employee Health Benefit Program
- GAO – Government Accountability Office
- GERD – Gastro Esophageal Reflux Disease
- MHS – Military Health System
- MTF – Military Treatment Facility
- P&T Committee – DoD Pharmacy and Therapeutics Committee
- PEC – Department of Defense Pharmacoeconomic Center
- PPI – Proton Pump Inhibitor (class of drugs)
- RN – Registered Nurse
- TMA – TRICARE Management Activity
- TMOP – TRICARE Mail Order Pharmacy
- TRRx – TRICARE Retail Pharmacy
- UF – DoD Uniform Formulary